(19)

No. 89-1048

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

FMC CORPORATION,

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICUS CURIAE THE AMERICAN CHIROPRACTIC ASSOCIATION IN SUPPORT OF RESPONDENT, CYNTHIA ANN HOLLIDAY

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INTEREST OF AMICUS CURIAE

The American Chiropractic Association ("ACA") represents 18,000 doctors of chiropractic from all across the nation.[1] The ACA seeks to promote chiropractic as a heal-

[1] The American Chiropractic Association has obtained the written consent of both FMC Corporation and Cynthia Ann Holliday to the filing of this amicus curiae brief. Original consent letters from the parties have been lodged with the Court.

ing profession and to serve as a spokesperson for the chiropractic profession in the United States. The question presented by this case—whether ERISA preempts application of a state anti-subrogation law to an employee benefit plan—is of great concern to all ACA members, their patients who participate in ERISA plans, and indeed, *all* health care consumers in the United States.

Health care costs are out of control. This should not be surprising since the 'invisible hand' of free market competition has long been paralyzed in the health care market. Decades of medical physician-dominance and control of the market have resulted in substantial exclusion of competitive, licensed health care providers in the largest sector of the health care market, especially in the area of health care insurance. For these and other reasons, many states have enacted insurance equality laws which require insurers to pay for services rendered by competitive health care providers such as chiropractors and podiatrists to the same extent "payment for the same services" would be made to medical physicians. In other words, the act does not mandate service—it mandates equality of insurance coverage notwithstanding the licensed providers of the service.

An interpretation of ERISA that would preempt application of these critically important state laws despite their lack of any impact whatsoever on any core ERISA concern, would not only harm all ACA members and their patients, but also greatly reduce any chance for competition among different types of health care providers in a huge portion of the health care market in this country.

SUMMARY OF THE ARGUMENT

ERISA's deemer clause, 29 U.S.C. §1144(b)(2)(B), should be interpreted to accommodate vital state interests in correcting serious problems in the health care insurance industry where the state laws in furtherance of that interest do not conflict with any ERISA provision or regulate areas already regulated by ERISA. Otherwise, state laws that enhance competition, reduce health care costs, and provide consumers with a modicum of freedom of choice will be void in a large segment of the immense and growing health care market governed by ERISA plans. Nothing in the legislative history of ERISA suggests that Congress intended the deemer clause to be read as a total bar to the application of such important state insurance laws to employee benefit plans. The deemer clause thus should not be read to provide such a draconian and unreasonable result.

ARGUMENT

I. Insurance Equality Of Licensed Provider Laws Provide Essential Competition And Freedom Of Choice Among Health Care Providers To Patients With Third Party Coverage

The cost of health care in this country is skyrocketing out of control. Health care costs jumped from 75.0 billion dollars, or 7.4 percent of GNP in 1970, to 458.2 billion dollars, or 10.9 percent of GNP in 1986. STATISTICAL ABSTRACT OF THE UNITED STATES, p. 90 U.S. Dept. of Commerce (1989). The country spent almost a half *trillion* dollars on health care, more than 11 percent of GNP in 1988. Health and Medical Services, U.S. Dept. of Commerce, *U.S. Industrial Outlook 1988*, 58-1 (1988).

Many commentators have come to the conclusion that one of the most important causes of the problem is the medical physician monopoly over health care, including health care insurance and financing.

> Physicians, not institutions, control the vast bulk of health care expenditures. Doctors determine when, how long, how intensively, and in what environment to treat patients. They order the laboratory tests, x-rays, pharmaceuticals, and surgery that determine the short-term institutional costs of treatment and that ultimately create the long-term demand for capital resources and insurance coverage. Although difficult to qualify with precision, informed estimates place 70 to 90 percent of health care expenditures within the control of individual practitioners.
>
> In order for health care cost containment to succeed, then, it is necessary for those institutions that employ, retain, or house doctors to implement new managerial control techniques that alter treatment behavior. Effective institutional control strategies, however, are unlikely to fit well within a legal structure that has evolved under a traditional, unrestrained reimbursement environment in which physician interests and authority have predominated.

Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 434 (1988). *See* Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 304-05 (1978) (a "root cause" of problems in health care cost containment "has been the [medical] profession's long-standing resistance to economizing innovations in the organization and administration of private plans for financing health care").

Through enormous power maintained by a variety of complex and subtle structural mechanisms, medical physi-

cians exercise a great deal of control of third party payment systems and who shall compete within them:

> . . . the profession's power, resulting not only from a surprising degree of consensus within the profession but also from a complex network of frequently subtle but always substantial controls and influences, has conditioned all actors in the health care system and effectively deterred all but the most modest attempts at change.

Hall, 1978 DUKE L.J. at 319.

One mechanism of medical physician control of health care financing is the "profession-dominated financing plan, such as Blue Shield or a county medical service bureau." *Id.* at 311. Commercial plans have followed suit:

> The commercial companies often operate at a distinct disadvantage in competition with the "Blues" [Blue Cross and Blue Shield]. Their competitive disadvantage and their vulnerability to boycotts [by medical physicians] appear to have caused the commercial insurers to accept the Blues' leadership on matters about which providers [medical physicians] feel strongly and to direct their competitive efforts elsewhere.

Id. at 338.

The monopolistic structure of the market has allowed medical physicians to control health care ideology and competitive health care providers. As Professors Havighurst and King have explained:

> The current organization and operation of the health care industry reflect the continued strength of the view that it should function as a single, essentially monopolistic system. Although no formal monopoly exists and many of the system's monolithic features have begun to break down, the medical profession

> still maintains significant control or influence at points where an outbreak of ideological diversity and decentralized decision making would threaten the [monopolistic] system's integrity. Because the antitrust laws now deny the [medical] profession the full range of formal controls that would be needed to manage the system completely, some diversity inevitably exists and is increasing. Yet, in practice, a high degree of standardization is still maintained, in large measure by virtue of a monopolistic ideology that contemplates that change should come not from independent entrepreneurial activity but from within the system as a matter of professional policy or negotiated consensus. The most intricate and complete mechanism for standardizing system inputs is that governing the training and labeling of personnel produced for service in the system.[2]

C. Havighurst & N. King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective*, 9 AM. J. L. & MED. 263, 266-67 (1983).

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[2] For an example of medical physician control of ideology and competition through powerful physician-dominated organizations such as the Joint Commission on Accreditation of Hospitals ("JCAH"), *see Wilk v. American Medical Ass'n*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, ___ U.S. ___ (June 11, 1990). As Professor Hall has explained in great detail, the JCAH accreditation standards are "powerfully influential." 137 U. PA. L. REV. at 527.

> JCAH standards decree an organized medical staff whose bylaws "establish a framework for self-governance." Notably the medical staff must have substantial authority over membership selection: it alone conducts the credentialing process that is the basis for determining admitting and treating privileges.
>
> Even without this statutory imprimatur, the JCAH, as the sole hospital accrediting organization, effectively has plenary authority over the structure of American hospitals. *See* Havighurst & King, *supra*. . . , at 323. Almost no hospital of significant size will risk the business consequences of operating without its seal of approval.

Id. at 529-530.

This entrenched, systematic control and exclusion of competitive health care providers has obviously reduced price and product or service competition in the health care market.

> Unfortunately, competition in health services has not focused enough on values, preferences, *costs*, or alternative ideas about how health needs should be met. Instead, because of the dominance of a single profession-sponsored ideology [of medical physicians], health care competition has concentrated primarily on the amenities surrounding the provision of an essentially uniform product.

Id. at 265. (emphasis added). This type of restriction in competition not only "deprive[s] individuals of the opportunity to obtain a desirable professional position" and "increase[s] the cost of medical services in an artificial and unnecessary way," but also greatly reduces consumers' freedom of choice. *See* Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WIS. L. REV. 1, 16.

Thus, the only way cost containment will come about is by breaking the medical physicians' grip on the health care market and opening it up to competition:

> Cost containment pressures will not relent until [medical] physicians have undergone a revolutionary change in behavior.
>
> . . .
>
> For decades, physicians have enjoyed essentially unfettered control over both medical practice and its workplace. Physicians gained control of access to medical practice at the turn of the century through licensing laws and medical education requirements that created a self-perpetuating, state-sanctioned monopoly. During the following quarter century, the medical

> profession harnessed the hospitals through accreditation standards that assured costless and unrestricted use of these capital-intensive facilities essential to modern practice.
>
> . . .
>
> The hospital industry, marked by a much greater degree of uniformity than other sectors of the economy, is particularly ripe for organizational innovation. . . .
>
> The [medical] profession's grip on the internal organization of hospitals must be broken in order for cost containment to succeed.

Hall, 137 U. PA. L. REV. at 443, 445-46, 505, 507.

Over the past 20 years, nearly every state has passed some type of "Equality of Provider" or "Freedom of Choice" law requiring insurers to pay for the services of non-medical physician health care providers,[3] to the extent

[3] Freedom of Choice insurance laws regulating health insurance policies have been adopted in nearly every state. *See* ALA. CODE at §27-1-10 (1975) (chiropractors); *Id.* at §27-1-11 (dentists); *Id.* at §27-19-39 (optometrists); *Id.* at §27-1-15 (Supp. 1989) (podiatrists); *Id.* at §27-1-18 (Supp. 1989) (psychologists and psychiatrists); ALASKA STAT. at §21.42.355 (1984) (nurse midwives); *Id.* at §21.89.040 (optometrists); ARIZ. REV. STAT. ANN. at §20-1406 (1984 & Supp. 1989) (optometrists, ophthalmologists, podiatrists, nurse practitioners, and licensed providers); *Id.* at §20-1406.01 (Supp. 1989) (psychologists and chiropractors); ARK. STAT. ANN. at §23-79-114 (1987) (optometrists, podiatrists, dentists, psychologists); CAL. INS. CODE at §10176 (West 1972 & Supp. 1989) (psychologists, social workers, counselors, speech pathologists, audiologists, registered nurses, psychiatric mental health nurses, chiropractors, dentists, podiatrists, opticians, optometrists, and occupational therapists); *Id.* at §10176.2 (physical therapists); COLO. REV. STAT. at §10-8-103(3)(a) (1973) (osteopaths, dentists, optometrists, psychologists, chiropractors, and podiatrists); CONN. GEN. STAT. ANN. at §38-174d (West Supp. 1990) (psychologists, psychiatrists, and social workers for child guidance clinics); *Id.* at §38-174h (dentists); *Id.* at §38-174q (occupational therapists); *Id.* at §38-174v (nurse midwives, nurse practitioners,

(Footnote continued on following page)

[3] *continued*
and psychiatric mental health clinical nurse specialists); DEL. CODE ANN. tit. 24, at §2101(c) (1981) (optometrists); *Id.* at §511 (Supp. 1988) (podiatrists); *Id.* at §717 (Supp. 1988) (chiropractors); FLA. STAT. ANN. at §627.419 (West 1988) (dentists, optometrists, podiatrists, and chiropractors); *Id.* at §627.6406 (nurse midwives); GA. CODE ANN. at §33-24-27(b) (1982) (psychologists and chiropractors); *Id.* at §33-24-27.1 (optometrists); HAW. REV. STAT. at §431-450 (1986) (optometrists); *Id.* at §431-499 (dentists); *Id.* at §431-500 (1986) (psychologists); IDAHO CODE at §41-2103 (1977) (podiatrists and optometrists); ILL. REV. STAT. ch. 73 at para. 976 (1989) (dentists); *Id.* at para. 976.1 (optometrists); *Id.* at para. 982b. (podiatrists); *Id.* at para. 982c. (psychologists); IND. CODE ANN. at §27-8-6-1 (Burns 1987) (dentists, health service providers in psychology, podiatrists, osteopaths, optometrists, and chiropractors); IOWA CODE ANN. at §509.3 (West Supp. 1990) (chiropractors, registered nurses, chiropodists); *Id.* at §514.7 (optometrists); KAN. STAT. ANN. at §40-2, 100 (1981) (optometrists, dentists, and podiatrists); *Id.* at §40-2, 104 (psychologists); KY. REV. STAT. §304.18-095 (Baldwin 1988) (optometrists, chiropractors & osteopaths); *Id.* at §304.18-097 (dentists); LA. REV. STAT. ANN. at §22:662 (West 1978) (podiatrists); *Id.* at §22:664 (optometrists); *Id.* at §22:665 (psychologists); *Id.* at §22:668 (chiropractors); *Id.* at §22:213.1 (West Supp. 1990) (dentists); *Id.* at §22:669 (social workers) (West Supp. 1990); ME. REV. STAT. ANN. tit. 24-A, at §2744 (Supp. 1989) (psychologists, social workers, and psychiatric nurses) *Id.* at §2748 (chiropractors); MD. ANN. CODE art. 48A, at §490 (1979) (podiatrists); *Id.* at §477-0 (1979 & Supp. 1989) (social workers); *Id.* at §477T (Supp. 1989) (nurse practitioners); *Id.* at §489 (Supp. 1989) (chiropractors); *Id.* at §490A (Supp. 1989) (psychologists); *Id.* at §490A-2 (Supp. 1989) (nurse midwives); MASS. GEN. LAWS ANN. ch. 175 at §108B (West 1987) (dentists); *Id.* at §110 (optometrists and podiatrists); *Id.* at §108D (chiropractors); MICH. COMP. LAWS ANN. at §500.2243 (West 1983) (optometrists); *Id.* at §500.3475 (psychologists, chiropractors, and podiatrists); *Id.* at §500.2239 (West Supp. 1990) (dentists); MINN. STAT. ANN. at §62A.043 (West 1986) (dentists and podiatrists); *Id.* at §62A.15 (optometrists, chiropractors, and registered nurses); *Id.* at §62A.152 (psychologists); MISS. CODE ANN. at §83-41-203 (1972) (optometrists); *Id.* at §83-41-209 (Supp. 1989) (dentists); *Id.* at §83-41-211 (Supp. 1989) (psychologists); *Id.* at §83-41-213 (Supp. 1989) (nurse practitioners); *Id.* at §83-41-215 (Supp. 1989) (chiropractors); MO. ANN. STAT. at §375.936(11)(b) (Vernon Supp. 1990) (optometrists, chiropractors, dentists, psychologists, pharmacists, and podiatrists); *Id.* at §354.027 ("person[s] duly licensed" to perform covered services); MONT. CODE ANN. at

(Footnote continued on following page)

[3] *continued*
§33-22-111 (1987) (dentists, osteopaths, chiropractors, optometrists, chiropractors, psychologists, social workers, nurse specialists, and pharmacists); NEB. REV. STAT. at §44-513 (1988) (osteopaths, chiropractors, optometrists, psychologists, dentists, and podiatrists); NEV. REV. STAT. at §689A.380 (1986) (dentists, osteopaths, chiropractors, oriental medicine, podiatrists, and optometrists); *Id.* at §689B.038 (psychologists); *Id.* at §689B.039 (chiropractors); N.H. REV. STAT. ANN. at §415:18-a (1983) (licensed pastoral counselors, psychologists, and psychiatrists); N.J. STAT. ANN. at §17B:27-50 (West 1985) (psychologists); *Id.* at §17B:27-51 (optometrists); *Id.* at §17B:27-51.1 (chiropractors); *Id.* at §17B:27-51.8 (dentists); N.M. STAT. ANN. at §59A-22-32 (Supp. 1989) (optometrists, psychologists, podiatrists, and nurse midwives); N.Y. INS. LAW at §3221 (McKinney 1985) (nurse midwives and social workers); *Id.* at §4235 (physical therapists, podiatrists, optometrists, dentists, psychiatrists, psychologists, and chiropractors); N.C. GEN. STAT. at §58-50-30 (1989) (optometrists, podiatrists, dentists, chiropractors, and psychologists); OHIO REV. CODE ANN. at §3923.23 (Page 1989) (osteopaths, optometrists, chiropractors, and podiatrists); *Id.* at §3923.231 (psychologists); *Id.* at §3923.232 (dentists); *Id.* at §3923.233 (nurse midwives); OKLA. STAT. ANN. tit. 36, at §6051 (West 1990) (optometrists); *Id.* at §3634 (podiatrists, psychologists, and clinical social workers); *Id.* at §6055 ("any practitioner" selected by the insured); PA. STAT. ANN. tit. 40, at §1511 (Purdon Supp. 1988) (osteopaths, dentists, chiropractors, podiatrists, and physical therapists); *Id.* at §3002 (nurse midwives); R.I. GEN. LAWS at §27-18-25 (1989); S.C. CODE ANN. at §38-71-200 (Law Co-op. 1989) (podiatrists, optometrists, and oral surgeons); *Id.* at §38-71-210 (chiropractors); S.D. CODIFIED LAWS ANN. at §58-17-53 (Supp. 1989) (optometrists); *Id.* at §58-17-54 (dentists, osteopaths, chiropractors, and podiatrists); TENN. CODE ANN. at §56-7-108 (1989) (optometrists, clinical psychologists, podiatrists, and social workers); *Id.* at §56-7-116 (chiropractors); *Id.* at §56-7-1002 (dentists); TEX. INS. CODE ANN. at §21.35A (Vernon 1989) (psychologists); *Id.* at §21.52 (Vernon 1989) (podiatrists, dentists, chiropractors, optometrists, audiologists, and speech-language pathologists); VA. CODE ANN. at §38.2-2203 (1986) (chiropractors); WASH. REV. CODE ANN. at §48.20.390 (1984) (podiatrists); *Id.* at §48.20.410 (optometrists); *Id.* at §48.20.411 (registered nurses); *Id.* at §48.20.412 (chiropractors); *Id.* at §48.20.414 (psychologists); *Id.* at §48.20.416 (dentists); W. VA. CODE at §33-6-30 (1988) (dentists, podiatrists, chiropractors, and optometrists); *Id.* at §33-16-3e (registered nurses and nurse midwives); WIS. STAT. ANN. at §628.33 (West 1980) (chiropractors); *Id.* at §632.87 (West Supp. 1989) (optometrists); WYO. STAT. at §26-22-101 (1983) ("person[s] licensed under laws of this state to treat the illness or disability or perform the health services"); *Id.* at §26-13-109 (dentists).

they would pay for the service if delivered by a medical physician. These laws go a long way toward opening up the health care market to at least some level of competition among providers. At the same time, they provide consumers with freedom to choose among licensed health care providers rather than requiring consumers to accept the uniform medical physician-dominated product the previously monopolized market would force upon them.

These Freedom of Choice laws regulate insurance. *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986). Because of the compelling State interest reflected in their passage, they should apply to self-funded benefit plans in even more compelling fashion than have anti-subrogation statutes or no-fault insurance plans. *See FMC Corp. v. Holliday*, 885 F.2d 79 (3rd Cir. 1989), *cert. granted*, ___ U.S. ___ (1990); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, ___ U.S. ___, 108 S. Ct. 1754 (1988).

II. The Deemer Clause Must Not Be Construed To Automatically Preempt Every State Insurance Law

A. The Deemer Clause Must Be Viewed In Light Of Its Congressional History To Determine The Proper Scope Of The Clause

Although ordinarily the words of a statute are the best indication of Congressional intent, courts have long recognized that a statute, when read unqualifiedly, may apply to situations wholly uncontemplated and unforeseen by Congress, leading to unreasonable results that Congress could never have intended.

> It is a familiar rule that a thing may be within the letter of the statute and yet not within the statute, because not within its spirit nor within the intention of its makers. . . . [F]requently words of general

> meaning are used in a statute, words broad enough to include an act in question, and yet a consideration of the whole legislation, or of the circumstances surrounding its enactment, or of the absurd results which follow from giving such broad meaning to the words, makes it unreasonable to believe that the legislator intended to include the particular act.

Holy Trinity Church v. United States, 143 U.S. 457, 459 (1892). In view of the expressed Congressional concern with the soundness and stability of benefit plans, it makes little sense that Congress meant to preempt state laws like Freedom of Choice laws that are directed at protecting consumers and at reducing health care costs through competition.

Nor does the legislative history of ERISA support a construction of the deemer clause that would preempt every state insurance law. It is undisputed that the language of ERISA's *preemption* clause, 29 U.S.C. §1144(a), together with its legislative history, demonstrate a Congressional intent to preempt all state laws "relating to" employee benefit plans. While the original versions of ERISA limited the scope of preemption to areas expressly covered by the bill, Congress expressly rejected that limited concept of preemption in favor of the present broad language of the preemption clause. It is equally clear from the language of the savings clause, 29 U.S.C. §1144(b)(2)(A), as well as its legislative history, that Congress meant to preserve the States' primacy in regulating insurance. Indeed, the Conference Committee Report stated "[t]he preemption provisions of Title I are not to exempt any person from any State law that regulates insurance." H. R. CONF. REP. NO. 93-1280, p. 383 (1974).

There is, however, no explanation in the legislative history of how the deemer clause was intended to relate to

the preemption clause and the savings clause, or of how much of the state-regulated field of insurance Congress intended to preempt. Determining the proper scope of the deemer clause is made more difficult by the fact that the first version of the deemer clause appeared in a House bill having a preemption clause of narrow scope. *See* H.R. 12906, SUBCOMM. ON LABOR OF THE HOUSE COMM. ON LABOR & PUBLIC WELFARE, 94TH CONG., 2D SESS., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 2920-22. The Conference Committee that was convened to work out differences between the Senate and House versions of ERISA, broadened the preemption clause while retaining the savings and deemer clauses, but gave no comments concerning the relationship between the broadened preemption clause and the deemer clause. H.R. CONF. REP. NO. 93-1280 p. 383 (1974).

This Court has long recognized that where an area has been traditionally occupied by the States, the assumption is that the police powers of the States were not to be superseded unless that was the clear and manifest purpose of Congress. *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). This assumption assures that the balance between federal and state powers will not be disturbed unintentionally by Congress or unnecessarily by the Courts. *Id.* In view of the lack of legislative comment regarding the proper scope of the deemer clause, it cannot be fairly said that Congress has demonstrated clearly and unequivocally that the application of *every* state insurance law to employee benefit plans was intended to be preempted.

B. Congress Did Not Intend The Deemer Clause To Preempt Every State Insurance Law

Although the language used by Congress in the deemer clause may appear to prevent the application of every state insurance law to every employee benefit plan, a closer review of the impact that such an interpretation would have on the health care market reveals that Congress could not have intended that result. Such absolute preemption of state insurance laws from applying to ERISA plans is not only inconsistent with Congressional intent to preserve state insurance laws, it in effect transfers to ERISA plan sponsors the power to legislate in areas unregulated by ERISA. Since ERISA does not regulate most substantive provisions of the plan contract, those plan provisions would become supreme law, requiring the automatic preemption of state law to resolve every conflict between the state law and the ERISA plan.

Certainly Congress could not have meant to defer its lawmaking authority to employers with self-funded ERISA plans, allowing them to adopt any plan provision they choose, so long as such plans comply generally with ERISA regulations. The potential for chaotic disruption of carefully crafted state regulatory schemes due to such absolute preemption is enormous. *See Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, ___ U.S. ___, 108 S.Ct. 1754 (1988).

Moreover, state laws, such as Freedom of Choice laws, that are directed specifically at correcting problems in the health care industry will have a significantly reduced impact on the medical care market if they are precluded from applying to self-funded plans. These laws have been enacted to counter the rising costs of health care and to further the public interest in health, welfare and safety

by promoting competition among providers and freedom of choice of providers by consumers for otherwise covered services. These goals are promoted by prohibiting discrimination against legally recognized and licensed professionals.

It is inconceivable that Congress intended the deemer clause to be construed as creating a "bright-line" distinction between self-funded plans and insured plans without at least some discussion regarding the impact that total preemption would have on such critically important insurance laws. Self-funded plans are becoming the rule, not the exception. Without a clear mandate from Congress indicating otherwise, this Court should not construe the deemer clause to preempt state insurance laws that promote competition among health care providers, increase freedom of choice for consumers, and reduce health care costs not only for plan participants, but for the plans themselves. The more reasonable approach, as recognized by the Court of Appeals for the Third Circuit, is to balance the federal interest in uniform regulation for employee benefit plans against the States' strong interest in uniformly regulating certain aspects of the insurance industry, such as cost containment regulations, that also impact on self-insured plans.

CONCLUSION

For the foregoing reasons, the American Chiropractic Association submits that the judgment of the Court of Appeals for the Third Circuit be affirmed.

Respectfully submitted,

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